3. STATE HEALTH CARE EXPENDITURES

This chapter examines Maryland residents' consumption of personal health care services in calendar year 1998. The detailed State Health Expenditure Accounts (SHEA) that follow analyze Maryland's health care expenditures by source of funds, delivery system, and type of service. Per capita expenditures for Maryland residents are presented to show increases that are not driven by population growth. The expenditure accounts address the following issues:

- ***What are the statewide health care expenditures?*** How have expenditures changed from 1997? What portion of expenditures is spent for physician services and hospital care? What services do remaining funds purchase?
- ***What portion of expenditures do Medicare, Medicaid, health maintenance organizations (HMOs), and private indemnity insurers pay?*** How have expenditures by each payer changed from 1997?
- ***What differences exist in the level and distribution of expenditures by type of delivery system, i.e., between managed care and traditional indemnity insurance?*** How have these differences changed over time?
- ***How much do patients have to pay for health care out of their own pockets?*** What portion of these payments is attributable to co-insurance and deductibles? How much is due to the lack of insurance?

As in previous years, the SHEA aggregates health expenditures across six major payers:

1. Medicare
2. Medicaid
3. Other government (non Medicare and non Medicaid) sources that include state and local governments
4. Private indemnity and other third party payers
5. Private HMOs
6. Individual residents (out-of-pocket expenses)

Expenditures are also aggregated by major categories of health services, such as hospital and physician services and nursing home care.

The Commission continues to refine its methodologies for estimating state health expenditures. Reported differences in expenditures between 1997 and 1998 should represent reasonable estimates of changes taking place in Maryland's health care market. The following changes were incorporated this year:

- Medicare indemnity expenditures by type of service and source of payment were estimated directly from claims data.
- New data sources were used to describe the distribution of private indemnity and HMO expenditures by type of service and the proportion of such expenditures paid out-of-pocket by Maryland residents.
- The Department of Corrections component of the other government sector distributed expenditures only to those regions that housed inmates under the Department of Public Safety.

These refinements were incorporated into both the 1997, Revised, and 1998 SHEA estimates to ensure comparability between years.

STATEWIDE HEALTH CARE EXPENDITURES IN 1998

This section discusses the fundamental issues addressed by the Maryland State Health Expenditure Accounts. That is, what are statewide expenditures on health care and how have those expenditures changed from 1997? It also examines how those expenditures are distributed by type of service, dividing expenditures into categories such as physician and hospital care.

Health care expenditures in Maryland rose by 5.3 percent in 1998, increasing to $17.0 billion (Table 3-1 and Appendix Tables 1A, 1B and 1E). This increase represents a higher rate of growth than in the previous three years, which corresponds to national trends. National health expenditures for the same

TABLE 3-1:MARYLAND STATE HEALTH CARE EXPENDITURES ACCOUNT (SHEA): TOTAL MARYLAND EXPENDITURES 1998 (000s)

	GOVERNMENT SECTOR					PRIVATE SECTOR						TOTAL EXPENDITURES
	Medicare		Medicaid		E. Other Governments	F. Indemnity & Other	G. HMO	Out-of-Pocket				
	A. Indemnity & Other	B. HMO	C. Indemnity & Other	D. HMO				H. Medicare (Coinsurance & Deductibles)	I. Private Plans (Coinsurance & Deductibles)	J. Uninsured Services	K. Total Out of-Pocket	
Total Health Expenditures	$3,250,785	$528,716	$1,771,152	$903,652	$834,019	$4,414,966	$2,428,175	$79,170	$911,664	$1,907,046	$2,897,879	17,029,343
Hospital Services												
Inpatient	1,698,222		437,959		177,187	932,078	558,197	18,569	79,697	1,258	99,524	3,903,166
Outpatient	396,330		52,235		52,740	466,645	292,241	18,320	98,623	6,981	123,924	1,384,116
Physician Services	636,750		40,121		98,464	1,327,925	938,734	29,749	449,155	149,870	628,774	3,670,767
Other Professional Services	94,898		177,412		370,082	230,933	105,018	2,965	132,684	777,414	913,062	1,891,405
Prescription Drugs			152,138		67,813	640,556	213,359		137,854	292,866	430,720	1,504,585
Nursing Home Care	175,518		603,488		16,826	8,830	3,111	8,678	438	448,459	457,575	1,265,347
Home Health Care	137,781		251,125		3,217	51,687	38,486	6	4,942	120,837	125,786	608,082
Other Services	22,317		15,781		22,048	36,674	18,871	884	8,271	109,361	118,516	234,206
HMO Capitation Payments		468,185		804,355								1,272,539
Admin. & Net Cost of Insurance	88,969	60,531	40,893	99,297	25,642	719,639	260,159					1,295,131

categories were projected to grow by 5.2 percent per annum from 1997 to 1998,[1] which represents an acceleration from the 4.3 percent national increase in 1997. [2] While current rates of increase are still far below the rapid growth seen in the late 1980s and early 1990s[3], national rates of increase in health care expenditures are predicted to increase even further.[4] Maryland's rate of growth in health expenditures has typically been consistent with the national average. It remains to be seen whether Maryland will mirror the national pattern of growth in subsequent years.

Statewide spending in 1998 on hospital care (inpatient and outpatient, combined) and on physician services was $5.3 billion and $3.7 billion, respectively, excluding expenditures associated with Medicare and Medicaid managed care plans. Hospital and physician services together account for more than half of all health care spending statewide, even though spending on these services was essentially unchanged from 1997. A simple comparison of 1998 to 1997 shows that expenditures on prescription drugs were up significantly, while spending on nursing home and home health care appeared to decline. However, the largest increases in spending statewide were associated with payments for Medicare and Medicaid beneficiaries enrolled in HMOs. Such Medicare "capitation" payments were up more than 52.6 percent from 1997, and Medicaid capitation increased by almost 163.7 percent as a result of the HealthChoice Program.[5]

The growth of Medicare and Medicaid managed care, combined with a lack of information about how public capitation dollars are spent, is making it increasingly difficult to compare changes in the distribution of expenditures by services. The SHEA methodology relies on secondary data sources to determine overall expenditures by payer. Government payers report expenditures for HMOs as a single category, without indicating how these expenditures are distributed among services. Because the Commission cannot assign government HMO expenditures to specific service categories, changes in service expenditures are difficult to analyze. This year's doubling of government expenditures on HMO services (following a similar doubling between 1996 and 1997) obscures changes in the level and distribution of expenditures by service category in the Medicare and Medicaid programs. Because Medicare and Medicaid account for a substantial portion of all health care spending in Maryland, these problems also make it difficult to determine the overall statewide expenditures by type of service.

Distributing public HMO expenditures based on private HMO spending patterns will better reflect spending for services that are covered by public HMOs but are either less well-covered or excluded from the corresponding indemnity coverage. For example, traditional Medicare does not provide coverage for prescription drugs, which is one of the most rapidly growing sectors of the health care industry, while Medicare managed care plans often use prescription drug benefits to attract beneficiaries into their plans.

The most notable effect of allocating aggregate government HMO expenditures across service categories is to revise the expenditure increases from 1997 to 1998 on inpatient hospital, outpatient hospital, and physician services from approximately zero to increases in the range of 4 to 8 percent (Table 3-2). In particular, if both 1997 and 1998 government HMO expenditures were distributed across services as described above, inpatient expenditures would show an increase of 3.6 percent, outpatient hospital expenditures would increase 6.4 percent, and spending on physician services would rise by 7.7 percent. However, these results may underestimate changes in the inpatient hospital sector, since Medicare beneficiaries tend to use

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[1] Health Care Financing Administration. National Health Care Expenditures Projections. http://www.hcfa.gov/stats/NHE-Proj (November 13, 1999).

[2] Health Care Financing Administration. National Health Care Expenditures. "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-97". http://www.hcfa.gov/stats/nhe-oact/nhe.htm (November 13,1999). The calculation of a national growth rate that is comparable to that used in the Maryland SHEA is based on the national health expenditures' personal health care category, adding administration and net cost of health insurance expenditures, deducting non-durable medical product expenditures (except for prescription drug expenditures), along with other federal expenditures, and expenditures in the other personal health care column.

[3] Health Care Financing Administration. National Health Care Expenditures. "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-97." http://www.hcfa.gov/stats/nhe-oact/nhe.htm (November 13, 1999).

[4] Smith, S., Heffler, S., Freeland, M., and others. The next decade of health spending: A new outlook. *Health Affairs* (18(4), pp. 86-95.

[5] Appendix Table 1B presents 1997 information comparable to that reported in Table 1A for 1998.

proportionately more inpatient services than the rest of the population. Independent data from the Maryland Health Services Cost Review Commission (HSCRC) on hospital revenue in Maryland show that total inpatient revenue remained flat between 1996 and 1997 and rose 4.8 percent between 1997 and 1998,[6] which is broadly consistent with the 3.6 percent estimated above. The HSCRC data also shows that inpatient utilization was almost unchanged between 1997 and 1998, with discharges increasing by only 0.1 percent.

TABLE 3-2: EFFECT OF DISTRIBUTING PUBLIC CAPITATION PAYMENTS TO THE SERVICE CATEGORIES ON 1998 EXPENDITURES AND 1997-1998 RATE OF GROWTH, BY TYPE OF SERVICE ($000s)

	Original 1998 Total Expenditures	Original 1998 Expenditures Distribution	Original 1997-1998 Percent Change	Revised 1998 Total Expenditures	Revised 1998 Expenditures Distribution	Revised 1997-1998 Percent Change
Total Health Expenditures	$17,029,343	100%	5.3%	$17,029,343	100%	5.3%
Hospital Services						
Inpatient	3,903,166	22.9%	-0.7%	4,243,963	24.9%	3.6%
Outpatient	1,384,116	8.1%	0.2%	1,562,538	9.2%	6.4%
Physician Services	3,670,767	21.6%	0.2%	4,243,894	24.9%	7.7%
Other Professional Services	1,891,405	11.1%	2.7%	1,955,522	11.5%	4.4%
Prescription Drugs	1,504,585	8.8%	9.4%	1,583,743	9.3%	13.0%
Nursing Home Care	1,265,347	7.4%	-6.6%	1,267,246	7.4%	-6.6%
Home Health Care	608,082	3.6%	-6.4%	631,579	3.7%	-4.5%
Other Services	234,206	1.4%	-2.8%	245,727	1.4%	-0.3%
HMO Capitation Payments	1,272,539	7.5%	109.3%			
Admin. & Net Cost of Insurance	1,295,131	7.6%	15.5%	1,295,131	7.6%	15.5%

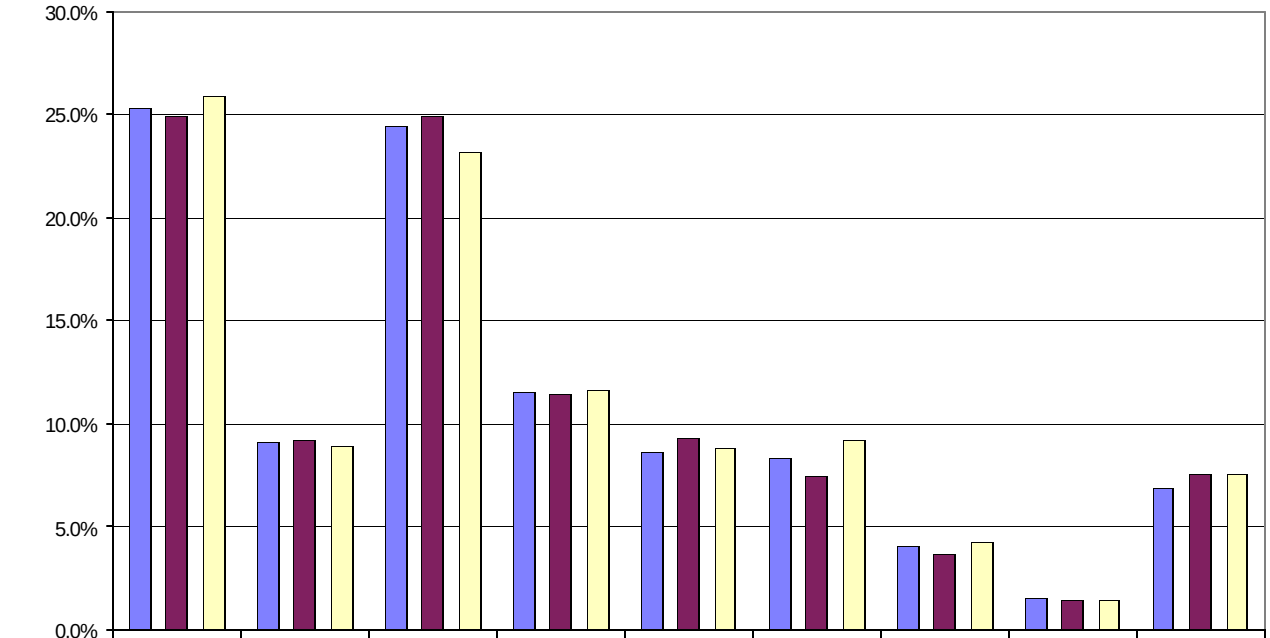
Figure 3-1 compares the statewide distribution of health spending across service categories in 1997 (SHEA 97) and 1998 (SHEA 98), distributing government HMO expenditures as indicated above. It also compares the statewide distribution of health spending in 1998 with the national distribution reported in the estimated 1998 National Health Expenditure Accounts (NHE 98).[7] Figure 3-1 suggests that the overall distribution of health care spending in the state did not change dramatically from 1997 to 1998. Maryland's overall distribution of health care dollars by service category is also similar to national figures in most categories. Generally speaking, Maryland appears to spend a slightly smaller proportion of its total expenditures than the national average on inpatient hospital, nursing home, and home health services. On the other hand, in Maryland, a greater proportion appears to be spent on outpatient hospital and physician services and prescription drugs. These differences may be due to the relatively high HMO penetration in Maryland (see discussion in Chapter 2), as HMOs tend to use a lower proportion of inpatient services and to offer prescription drug coverage. However, most of these differences are small enough that they may not be meaningful, given differences in the way the SHEA and the national health accounts are constructed.

This year's 5.3 percent growth in total expenditures (Table 3-3) could result from several factors: increased enrollment among specific insured populations, improved access to care within insured populations, changes in the intensity or volume of services used by individual program enrollees, or general and medical care price inflation. From 1997 to 1998, the Consumer Price Index for medical care services increased about 3.4 percent nationally and 2.6 percent in the Baltimore/Washington DC Metropolitan Area, as discussed in

[6] Health Services Cost Review Commission. "Selected statistics for 12 months ending December 1996, December 1997, and December 1998. Total revenue, inpatient revenue, admission and charge per admission."

[7] Health Care Financing Administration. National Health Care Expenditures. "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-97". http://www.hcfa.gov/stats/nhe-oact/nhe.htm (November 13, 1999). Service category distribution is calculated using the national categories that correlate to the 1997 SHEA, as noted in footnote 1.

Figure 3-1: Where Did Maryland's Health Dollar Go in 1997 and 1998?



	Inpatient	Outpatient	Physician Services	Other Professional Services	Prescription Drugs	Nursing Home Care	Home Health Care	Other Services	Admin. & Net Cost of Insurance
SHEA 97	25.3%	9.1%	24.4%	11.6%	8.7%	8.4%	4.1%	1.5%	6.9%
SHEA 98	24.9%	9.2%	24.9%	11.5%	9.3%	7.4%	3.7%	1.4%	7.6%
NHE 98	25.9%	8.9%	23.2%	11.6%	8.8%	9.2%	4.3%	1.5%	7.6%

TABLE 3-3: COMPONENTS OF 1997-1998 EXPENDITURE GROWTH

Medical Price Inflation	2.6%
Population Growth	0.8%
Other Factors (including aging of the population)	1.9%
Total Increase In Expenditures	5.3%

Chapter 2. These increases suggest that about half of the overall expenditure increase was due to general medical inflation.[8] Chapter 2 indicates that another 0.8 percent can be attributed to population increase. Some of the remaining increase is due to increased enrollment in government programs and the demand for services associated with the aging of the population. Finally, rising discretionary spending driven by growing personal income fueled some of the expenditure growth. These effects are discussed in more detail in Chapter 2.

[8] Health Care Financing Administration. "Health Care Indicators: Hospital, Employment, and Price Indicators for the Health Care Industry". Medical Prices. Table 8. Index Levels of Medical Prices, 1995-1999. http://www.hcfa.gov/stats/indicatr/tables/t08.htm (November 8, 1999).

ABOUT MARYLAND'S HEALTH CARE EXPENDITURE ACCOUNTS

Data to support these accounts were gathered from many sources, including annual financial reports by payers to the Maryland Insurance Administration (MIA). Additional information was obtained from the Health Care Financing Administration (HCFA) and Maryland's Medicaid Program, administered by the Department of Health and Mental Hygiene (DHMH). Data used to develop the account of other government expenditures were obtained and analyzed from Maryland's Department of Corrections, DHMH state and local program budget documents, DHMH state hospital budget documents, U.S. Department of Veterans Affairs, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Additionally, data from two state-funded programs, the Pharmacy Assistance Program and the AIDS Insurance Assistance Program, were included in this payer category.

To the extent possible, MHCC collected expenditure data for health services that were rendered in calendar year 1998. Private indemnity insurers and HMOs report expenditures by date of incurred services to the MIA for each calendar year. Some secondary data from payers were only available in forms that did not conform to the 1997 service period. Data on state and county health department health expenditures, including Medicaid, are organized by the date payment was made to the provider and are summarized by fiscal year (July 1 to June 30). For those expenditures, the average of state fiscal years 1998 and 1999 (which includes the last 6 months of calendar year 1998) was used to estimate calendar year 1998 expenditures. Because these data reflect when payment was made, a small portion of the expenditures reported here for 1998 actually occurred in late 1997. This is balanced somewhat by the fact that some services delivered in late 1997 were not captured because payment was not actually made until 1998.

Out-of-pocket expenditures are made by insured individuals to pay for co-insurance and deductibles on services and by individuals and philanthropic organizations to pay for non-covered goods and services. Non-covered services include not only those services consumed by individuals without insurance coverage, but also services not covered under health plans of insured individuals. Out-of-pocket spending does not include spending for premiums that fund health insurance. National out-of-pocket expenditure information and its relation to total personal health expenditures were used to estimate Maryland's total out-of-pocket spending for 1998. Using this information in conjunction with information on Medicare and private plan co-insurance and deductibles allowed for estimates of uninsured expenditures by service category.

Enrollment information was gathered for each source of insurance coverage and delivery system to facilitate analysis of spending trends. These data also were used as the basis for determining the denominators for per capita expenditures reported in this chapter. It is important to note that about 54,000 Medicaid enrollees also were dually enrolled in the Medicare Program in 1998. This group receives services from both programs, but they are counted as Medicare enrollees. An attempt has been made to remove their Medicaid spending from the Medicaid totals reported here whenever comparisons are made between spending by Medicare and Medicaid beneficiaries. The total enrollments shown in tables and represented in graphs in this chapter represent the total for the three major sources of insurance coverage. Coverage by CHAMPUS or enrollments in single benefit programs, such as dental insurance, are not included in total enrollment.

Development of a state system for reporting health expenditures is an ongoing process. In order to identify trends, year-to-year consistency in method and format is required. Despite some refinements in our methodology for estimating health care spending, where possible, MHCC methods are consistent with those used in 1996 and 1997. As could be expected, methodological enhancements were identified and applied in developing the 1998 expenditure estimates. Although enhancements made this year will improve accuracy and consistency of reports over time, they have the short-term effect of producing inconsistent comparisons with previous years. To make some 1997 to 1998 comparisons with confidence that trends are due to changes in health care delivery and financing, rather than changes in methodology, MHCC has adjusted the 1997 health expenditure accounts using improvements developed for 1998. Where it was not possible to develop 1997 data consistent with 1998 methodologies, no attempt was made to compare the two years. Because of this limitation, MHCC has chosen not to compare 1997 and 1998 regional expenditures as part of the discussion in Chapter 4.

EXPENDITURES BY SOURCE OF PAYMENT

This section describes the distribution of total expenditures by source of payment, looking at total dollar amounts and percentages of the total health care expenditures, as well as the distribution of payer expenditures among the various services. It focuses specifically on the portion of expenditures paid by Medicare, Medicaid, and private health plans. This section also describes how expenditure patterns have changed over time and how expenditures vary by type of service and source of coverage.

EXPENDITURES BY PAYER

Most payers experienced relatively strong growth in total health expenditures, as reported in Table 3-4. Aggregate government expenditures increased 4.4 percent, while private expenditures increased 6.0 percent (Table 3-4). The growth experienced by both the government and private sectors this year appears to reflect marketwide factors, rather than growth that is driven only by certain payers. This same pattern was observed last year. However, Medicaid expenditures in 1998 increased slightly more than spending by other government payers. The lower rate of increase for the aggregate government sector, as compared with the private sectors, is largely due to a 3.7 percent reduction in "Other Government" spending and the only payer category which experienced a decline in total expenditures.

TABLE 3-4: MARYLAND'S HEALTH EXPENDITURES ($000s) IN GOVERNMENT AND PRIVATE SECTORS: 1997-1998

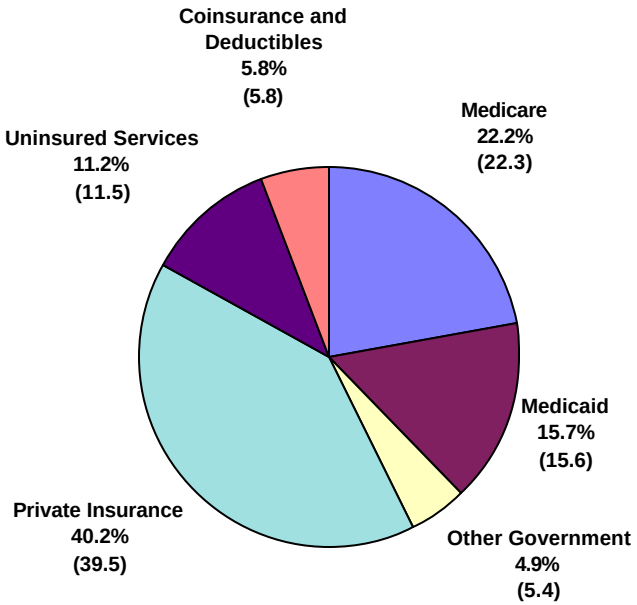
	Government Sector				Private Sector			
Expenditures	Medicare	Medicaid	Other Govt.	Total Govt.	Privately Insured	Out-of-Pocket	Total Private	Total
1997	3,598,346	2,516,660	865,665	6,980,671	6,381,242	2,804,283	9,185,525	16,166,196
1998	3,779,500	2,674,804	834,019	7,288,323	6,843,141	2,897,879	9,741,020	17,029,343
% Change 1997-98	5.0%	6.3%	-3.7%	4.4%	7.2%	3.3%	6.0%	5.3%

Reductions in "Other Government" spending reflect changes in state fiscal policy, as well as specific changes in the financing of mental health services. Specifically, the state switched from a grants-based system in FY1997 to a fee-for-service system in FY1998 that paid mental health providers only when services were actually delivered. The state also implemented a gatekeeper approach to managing mental health services. The net effect was to reduce state spending on mental health services—which is a large portion of the "Other Government" category—significantly.

In general, Maryland maintained similar proportions of health care expenditures from 1997 to 1998 (Figure 3-2). In each of the years for which the SHEA has been produced, Maryland has followed the national trend of increased public-sector funding for health care. The private sector (private insurance, uninsured services, and co-insurance and deductibles) still covers the majority of health expenditures in the state (57.2 percent), but government payers have usually increased their share of the overall health dollar. This year, the pattern changed slightly in Maryland, as the government share (Medicare, Medicaid, and Other Government) of total spending declined from 43.3 to 42.8 percent following small increases in the previous two years.

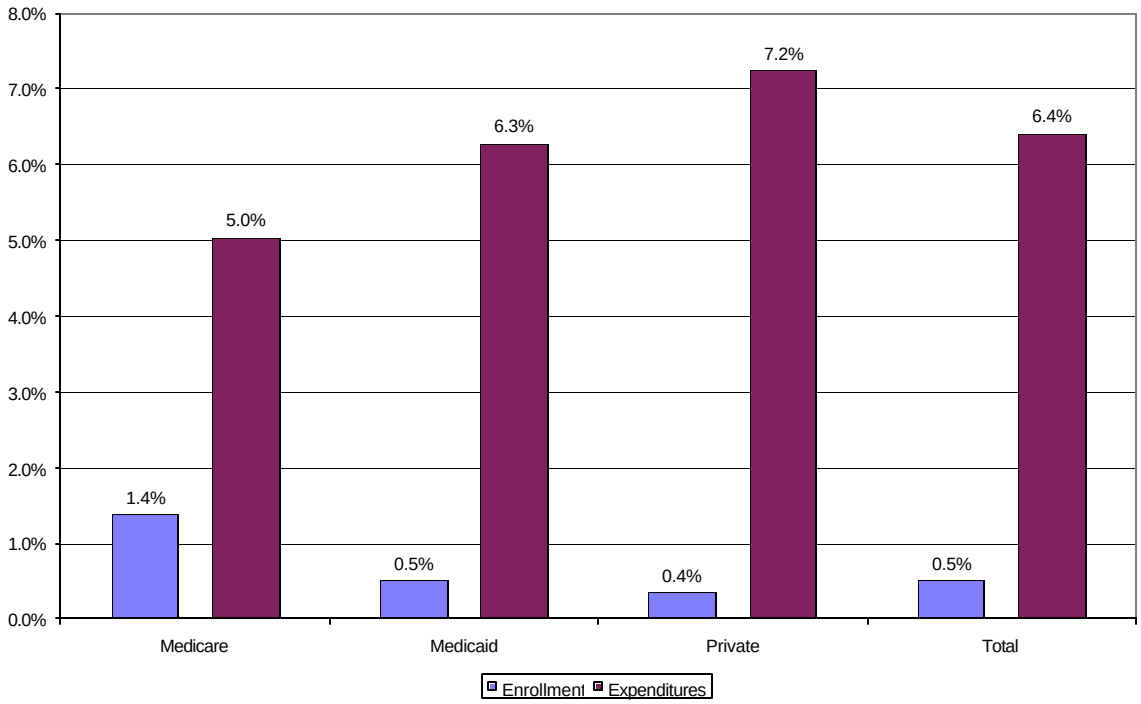
Private insurance expenditures represented 40.2 percent of total expenditures for health care in 1998. Medicare—the largest government payer—funded almost one-quarter (22.2 percent) of all expenditures, and Medicaid funded about 15.7 percent of expenditures. Private individuals' out-of-pocket expenditures for co-insurance, deductibles, and uninsured services represented 17 percent of all expenditures, which is the sum of the estimated 5.8 percent spent on co-insurance and deductibles and 11.2 percent spent for uninsured services. This aggregate percentage was slightly lower than in 1997 (17.3 percent), which also declined slightly from 1996.

Figure 3-2: Where Did the Maryland Health Dollar Come from in 1998 (1997)?
Total Dollars = 17.0 Billion (16.2 Billion)



Note: 1997 figures shown in parentheses

Figure 3-3: Percent Change in Total Enrollment and Expenditures by Source of Coverage: 1997-1998



A comparison of changes in enrollment versus expenditures from 1997 to 1998 shows small increases in enrollment coupled with greater increases in expenditures across all payers, as shown in Figure 3-3. Medicare enrollees increased 1.4 percent in 1998, the Medicaid population grew 0.5 percent, and the privately insured population grew 0.4 percent. However, changes in enrollment are only a small part of the explanation for why expenditures increased by payer, from 1997 to 1998. In fact, private insurance had the largest increase in expenditures (7.2 percent), even though it had the smallest increase in enrollment. In contrast, Medicare had the smallest increase in spending (5.0 percent) and the largest increase in enrollment.

TOTAL SPENDING BY SOURCE OF COVERAGE AND TYPE OF SERVICE

This section describes the distribution of total expenditures by source of payment, looking at total dollar amounts and percentages of total health care expenditures, as well as the distribution of payer expenditures among the various services. The differences between managed care and indemnity insurers are discussed later in this chapter.

Among non-HMOs, government programs spend proportionately more on inpatient hospital services, and private plans spend proportionately more on physician services and prescription drugs (Table 3-5). The proportion of total dollars spent on various service categories varies widely by payer, but variations correspond closely with differences in payer health plan benefit packages and with differences in the health care needs of the population groups associated with payers. It is important to note that, because government expenditures on HMOs cannot be categorized by service category, comparisons among payer sources are limited to the non-HMO sector.

Several variations due to benefit packages are apparent in Table 3-5. As the only payer in either the government or private sector that offers more than post-acute coverage for nursing home services, Medicaid spends a much larger share of its dollars on long-term care services than does any other payer. More than one-third (34.1 percent) of all non-HMO Medicaid expenditures are for nursing home care. Private non-HMO third party payers expend less than 1 percent of their total dollars on nursing home care. Many private-sector plans offer prescription drug coverage, whereas the Medicare standard benefit package does not include any prescription drug benefits. For this reason, private non-HMOs spend 14.5 percent of total dollars on prescription drugs, while government programs spend proportionately less (0 percent for Medicare non-HMOs and 8.6 percent for Medicaid non-HMOs). This is an artifact of variations in benefit packages. The lower percentage of Medicaid expenditures on prescription drugs is due to the diluting effect of the much higher percentages of Medicaid expenditures for nursing home and home health care.

As shown in Table 3-5, variations in service category distributions of expenditures are also a result of the widely different populations served by Maryland payers. Medicare, as the primary payer for the over-65 population, incurs a higher proportion of its expenditures for inpatient services in its non-HMO program than do the private non-HMO third party payers (52.2 percent versus 21.1 percent). Private non-HMO payers spend a higher proportion of their total dollars on physician services than Medicare does for non-HMO beneficiaries (30.1 percent versus 19.6 percent), reflecting the fact that a younger enrollee population uses relatively more routine and preventive care than hospital care. The Medicaid population also has a relatively low proportion of expenditures for inpatient care (24.7 percent). The Medicaid experience is only slightly larger than that of privately insured individuals, regardless of whether the latter have indemnity or HMO coverage.

One factor that complicates the interpretation of private expenditure data in the SHEA for both HMOs and non-HMOs is the practice of "carving out" specific services, such as mental health and prescription drugs. The SHEA estimates of private expenditures are based on submissions to the Maryland Insurance Administration (MIA) by private insurance companies and HMOs. To the extent that employers or other groups purchase specialty services directly from providers, the expenditures reported in the SHEA will tend to underestimate actual spending because the dollars do not flow through insurance arrangements within the

TABLE 3-5: DISTRIBUTION OF MARYLAND HEALTH EXPENDITURES BY SOURCE OF FUNDING, 1998.

EXPENDITURE COMPONENTS	NON-HMO THIRD PARTY					HMO			OUT-OF-POCKET	GRAND TOTAL
	Medicare	Medicaid	Other Govt	Privately Insured	Total	Medicare	Medicaid	Privately Insured		
Total Expenditures	100%	100%	100%	100.0%	100.0%	100%	100%	100%	100%	100%
Hospital Services										
Inpatient	52.2%	24.7%	21.2%	21.1%	31.6%			23.0%	3.4%	22.9%
Outpatient	12.2%	2.9%	6.3%	10.6%	9.4%			12.0%	4.3%	8.1%
Physician Services	19.6%	2.3%	11.8%	30.1%	20.5%			38.7%	21.7%	21.6%
Other Prof. Svcs.	2.9%	10.0%	44.4%	5.2%	8.5%			4.3%	31.5%	11.1%
Prescription Drugs		8.6%	8.1%	14.5%	8.4%			8.8%	14.9%	8.8%
Nursing Home Care	5.4%	34.1%	2.0%	0.2%	7.8%			0.1%	15.8%	7.4%
Home Health Care	4.2%	14.2%	0.4%	1.2%	4.3%			1.6%	4.3%	3.6%
Other Services	0.7%	0.9%	2.6%	0.8%	0.9%			0.8%	4.1%	1.4%
HMO Cap. Pmts.						88.6%	89.0%			7.5%
Admin. & Net Cost of Insurance	2.7%	2.3%	3.1%	16.3%	8.5%	11.4%	11.0%	10.7%		7.6%

jurisdiction of the MIA. A similar problem involves situations in which large groups choose to self-insure for specific services while providing insurance or health plan coverage for the remainder of their health benefits program.

Table 3-6 shows how total expenditures and expenditures on services are distributed among the payers. Comparing the proportion of total expenditures in the state that are covered by a particular payer to that same payer's proportion for a particular service allows identification of specific categories of service in which a payer is spending disproportionately to the overall share of the expenditures. Benefit package design and program population characteristics both influence the proportions of spending, as discussed below.

TABLE 3-6: GOVERNMENT AND PRIVATE EXPENDITURES BY SERVICE CATEGORY AS A PERCENT TOTAL EXPENDITURES: 1998

EXPENDITURE COMPONENTS	GOVERNMENT SECTOR:				PRIVATE SECTOR:			TOTAL
	Medicare	Medicaid	Other Govt	Total Govt	Private	Out-of-Pocket	Total Private	
Total Expenditures	22.2%	15.7%	4.9%	42.8%	40.2%	17.0%	57.2%	100%
Hospital Services								
Inpatient	43.5%	11.2%	4.5%	59.3%	38.2%	2.5%	40.7%	100%
Outpatient	28.6%	3.8%	3.8%	36.2%	54.8%	9.0%	63.8%	100%
Physician Services	17.3%	1.1%	2.7%	21.1%	61.7%	17.1%	78.9%	100%
Other Prof. Svcs.	5.0%	9.4%	19.6%	34.0%	17.8%	48.3%	66.0%	100%
Prescription Drugs		10.1%	4.5%	14.6%	56.8%	28.6%	85.4%	100%
Nursing Home Care	13.9%	47.7%	1.3%	62.9%	0.9%	36.2%	37.1%	100%
Home Health Care	22.7%	41.3%	0.5%	64.5%	14.8%	21%	35.5%	100%
Other Services	9.5%	6.7%	9.4%	25.7%	23.7%	50.6%	74.3%	100%
HMO Capitation Pmts.	36.8%	63.2%		100.0%				100%
Admin. & Net Cost of Insurance	11.5%	10.8%	2.0%	24.3%	75.7%		75.7%	100%

The government sector funds 42.8 percent of all expenditures in the state (Table 3-6). However, it funds the majority of expenditures for hospital inpatient care (59.3 percent), nursing home care (62.9 percent), and home health care (64.5 percent). The disproportionate share of inpatient care expenditures is driven largely by the Medicare population, which tends to use proportionately more hospital care than younger populations. Medicare funds less than one-quarter of all state health expenditures (22.2 percent), but it pays for 43.5 percent of all inpatient care expenditures.

Although Medicaid represents only 15.7 percent of total Maryland expenditures, it funds almost half of all nursing home and home health expenditures in the state (47.7 percent and 41.3 percent, respectively). Medicaid funds proportionately less than its total share of expenditures for hospital outpatient, physician, and other professional services, but part of this is due to the high level of expenditures on nursing home and home health care.

The private sector funds the majority of health expenditures in the state (57.2 percent), yet it funds over three-quarters of all expenditures for physician services (78.9 percent) and more than 85 percent of all prescription drug expenditures. Private insurance funds 40.2 percent of all state health expenditures but it accounts for 61.7 percent of all physician services, 56.8 percent of the expenditures on prescription drugs, and 54.8 percent of outpatient hospital spending.

PER CAPITA EXPENDITURES IN 1998

The average overall per capita expenditure across all residents for all services including administration in 1998 was $3,316, up 4.5 percent from the 1997 figure of $3,173. Per capita expenditures grew more slowly than total spending in Maryland because of 0.8 percent population growth, as reported in Chapter 2. Average per capita expenditures excluding administration grew 3.8 percent, slightly less than overall per capita spending due to the steep rise in administrative costs in 1998 (Appendix Table 3).

The statewide per capita spending figure is the result of payer-specific differences in average per capita spending and the size of the covered populations. Per capita spending varies considerably by type of insurance.[9] Excluding administration and the net cost of insurance, but including out-of-pocket outlays, privately insured individuals incurred an average of $1,946 in 1998, while Medicaid enrollees had a per capita figure of $5,639 and Medicare beneficiaries incurred $6,453 per person, on average. For this reason, the increase in statewide spending was influenced by changes in how the state population was distributed among payers. As discussed earlier, the largest enrollment increase, 1.4 percent, occurred among the most expensive individuals, the Medicare population. The Medicaid enrollment increased by 0.5 percent, while the number of people with private insurance increased 0.4 percent (Figure 3-3). The increase in the Medicare enrollment, with the considerably higher per capita expenditures for Medicare enrollees, helped to drive up the overall statewide per capita spending level.

The Consumer Price Index for medical services rose 2.6 percent between 1997 and 1998 in the Baltimore/Washington DC Metropolitan Area.[10] This reflects increases in the prices of services. The balance of the 3.8 percent increase in per capita expenditures is due to increases in services and administrative expenses. Increases in the number of services provided could be due to the aging of the population, which is confirmed by the increase in the proportion of the population enrolled in Medicare. However, this effect would be somewhat counterbalanced by the increased enrollment in HMOs, which tends to reduce utilization of services, as well as changing the mix of services consumed.

PER CAPITA DIRECT SPENDING FOR DIFFERENT POPULATION GROUPS

Another way to look at per capita expenditures is to focus on direct spending, excluding administrative costs and the net cost of insurance. Direct spending provides a basis for understanding differences in health care utilization that are not confounded by such issues as who pays for utilization review and periodic changes in accounting standards.

Direct per capita expenditures for the insured population increased 5.0 percent from 1997 to 1998, excluding administrative expenses and the net cost of insurance. However, Table 3-7 shows considerable variation in the rate of increase by payer. The privately insured show the largest increase, 6.8 percent from 1997 to 1998. Medicaid experienced an increase of 4.9 percent from 1997 to 1998, following a more modest 2.6 percent rise from 1996 to 1997. Average per capita spending for Medicare beneficiaries rose

[9] One problem in developing per capita estimates from the SHEA is the fact that some people have more than one type of coverage. For example, approximately 58,000 Maryland residents in federal FY1998 were covered by both Medicare and Medicaid. Another 43,000 residents had private insurance and Medicaid coverage. In constructing the payer-specific per capita estimates reported in this section, an effort was made to correct for this "double-counting" and to ensure that the expenditures in the numerator of the per capita ratio matched the individuals included in the denominator. Medicare expenditures include all Medicare Program payments made on behalf of Maryland residents plus co-insurance and deductibles due for indemnity services, regardless of whether they are paid by supplemental private insurance ("MediGap"), Medicaid, or beneficiaries themselves. The creation of a Medicaid per capita figure is more problematic because Medicaid actually involves several different programs with varying eligibility criteria and benefits. It is not possible to portray this multidimensional public program accurately with a single number. Nevertheless, for the purpose of this discussion, Medicaid per capita expenditures include all program payments. Medicaid beneficiaries in the denominator exclude participants in the Maryland Pharmacy Assistance Program (MPAP), the Family Planning Program (FPP), and the Maryland Kids Count (MKC) program. Private insurance per capitas are defined for all insured individuals who do not have Medicare, Medicaid, or CHAMPUS coverage. Privately insured expenditures include payments by fee-for-service insurers, capitation payments made to HMOs, and co-insurance and deductibles paid by enrollees. Privately insured expenditures do not include payments made by fee-for-service insurers to reimburse for Medicare co-insurance and deductibles.

[10] See Chapter 2, page 19, for a more detailed discussion of medical price inflation in 1998 as measured by the Consumer Price Index and the Producer Price Index.

1.9 percent from $6,330 in 1997 to $6,453 in 1998. The Medicare Program also had the smallest increase (1.1 percent) from 1996 to 1997. In all likelihood, the small increase for Medicare can be attributed to two factors: the Balanced Budget Act of 1997, which imposed a series of reductions in Medicare reimbursement for various covered services, and the relatively large shift of Medicare beneficiaries from traditional indemnity coverage into Medicare HMOs.

TABLE 3-7: MARYLAND AVERAGE PER CAPITA DIRECT EXPENDITURES BY SOURCE OF COVERAGE: 1998

	Medicare	Medicaid	Privately Insured	All Insured
1997	$6,330	$5,377	$1,823	$2,803
1998	$6,453	$5,639	$1,946	$2,942
% Change 1997-1998	1.9%	4.9%	6.7%	5.0%

Note: Excludes Administrative Expenses and the Net Cost of Insurance.

The variation in the level of per capita expenditures by payer source reflects the different health care needs and benefit packages of the insured populations of Medicare and Medicaid enrollees. Average per capita expenditures for Medicare recipients are three-and-a-half times those of the privately insured, and per capita expenditures for Medicaid recipients are nearly three times those of the privately insured population. The relatively high level of Medicaid spending results from the enrollee health status, the comprehensive benefit package provided by Medicaid, and the expense involved in offering a nursing home benefit.

The 1.9 percent increase in per capita expenditures for Medicare beneficiaries contrasts with a 1.2 percent decrease nationally.[11] Several factors account for the difference. The 1.9 percent increase shown in the Maryland SHEA includes all expenditures for Medicare recipients, including capitation payments and co-insurance and deductibles paid by Medicaid (as noted above). Unexpectedly, the higher rate of growth in per capita expenses for Maryland Medicare residents occurred in spite of the fact that they are moving into Medicare HMOs at a more accelerated rate than are beneficiaries nationally. There is no national basis for evaluating these reported changes, since HCFA does not report per capita expenditures for Medicare and Medicaid through the National Health Accounts project because of limitations with the measure for these populations.[12]

Overall per capita expenditures for the privately insured population increased by 6.7 percent, which is higher than the 5.6 percent increase that occurred from 1996 to 1997. Per capita spending by the privately insured should be of special interest to employers and organized labor because it approximates expenditures per private insurance enrollee.[13] The increase in per capita expenditures for the privately insured population can be split into two components: the insurer payments and the out-of-pocket payments. Insurer per capita payments increased from $1,565 in 1997 to $1,673 in 1998, an increase of 6.9 percent (Table 3-8). Out-of-pocket payments increased an estimated $16 per person, or 6.2 percent, over the same time period.

TABLE 3-8: MARYLAND AVERAGE PER CAPITA EXPENDITURE FOR PRIVATELY- INSURED COVERED SERVICES (HMO AND NON-HMO): 1997-1998

	Insurer Payment	Out-of-Pocket Payment	Total Payment
1997	$1,565	$257	$1,823
1998	$1,673	$273	$1,946
% Change 1997-1998	6.9%	6.2%	6.7%

[11] Health Care Financing Administration. National Health Care Expenditures Projections. http://www.hcfa.gov/stats/ENRLTRND.htm (November 30, 1999) and http://www.hcfa.gov/stats/INDICATR/tables/t03.htm

[12] Health Care Financing Administration. National Health Expenditure Tables. Table 4. Personal Health Care Expenditures Aggregate and Per Capita Amounts and Percent Distribution, by Source of Funds. http://www.hcfa.gov./stats/nhe-oact/tables/t12.htm (November 13, 1999).

[13] The privately insured figure does not include expenditures for Medicare supplemental insurance.

COMPARISONS BETWEEN MANAGED CARE AND INDEMNITY

Chapter 2 discussed in some detail the statewide shift into managed care arrangements. Unlike traditional indemnity-type insurance arrangements, HMOs and other types of managed care provide an administrative process that is designed to improve clinical decision making. Combined with financial incentives that are designed to encourage the efficient delivery of services, the growth of managed care represents a significant change in the organization and financing of health care in Maryland. For this reason, it is important to consider what differences exist in the level and distribution of expenditures by type of delivery system and how these differences have changed over time.

The statewide shift into managed care arrangements is reflected in the expenditure patterns shown in Table 3-9. For example, Medicare HMO expenditures increased more than 50 percent from 1997 to 1998, while expenditures by Medicare beneficiaries with more traditional indemnity coverage stayed the same. In the Medicaid Program, implementation of HealthChoice caused HMO expenditures to nearly triple, increasing 163.7 percent, while overall spending by Medicaid recipients, who remain in indemnity arrangements, fell by 18.5 percent. Interestingly, the rapid increase in expenditures governed by managed care arrangements in the public sector does not carry over to the private sector. Here, total HMO-related spending increased 6.3 percent from 1997 to 1998, while expenditures under indemnity arrangements went up 7.8 percent. The more stable rates of growth in the private sector reflect modest declines in HMO enrollment and the fact that managed care is a more established and mature phenomenon in this segment of the industry.

TABLE 3-9: TOTAL MARYLAND HEALTH EXPENDITURES ($000s) BY DELIVERY SYSTEM AND SOURCE OF COVERAGE: 1997-1998

	HMO				Non-HMO Third Party			
	Medicare	Medicaid	Private	Total	Medicare	Medicaid	Private	Total
1997	$346,380	$342,662	$2,284,428	$2,973,470	$3,251,966	2,173,999	$4,096,814	$9,522,779
1998	$528,716	$903,652	$2,428,175	$3,860,543	$3,250,785	1,771,152	$4,414,966	$9,436,903
% Change 1997-1998	52.6%	163.7%	6.3%	29.8%	0.0%	-18.5%	7.8%	-0.9%

The distribution of health care expenditures by source of funding was presented earlier in Table 3-5. This table facilitates comparisons based on funding sources, but it also allows a comparison of expenditure distributions by private HMOs and non-HMOs, since data on private HMO expenditures by service category are available. Presumably, HMOs make more effort to substitute outpatient and preventive care for more expensive services. While HMO efforts to contain expenditures have certainly had spillover effects in the non-HMO market, most experts still believe that HMOs have made more of these shifts than have non-HMO payers.

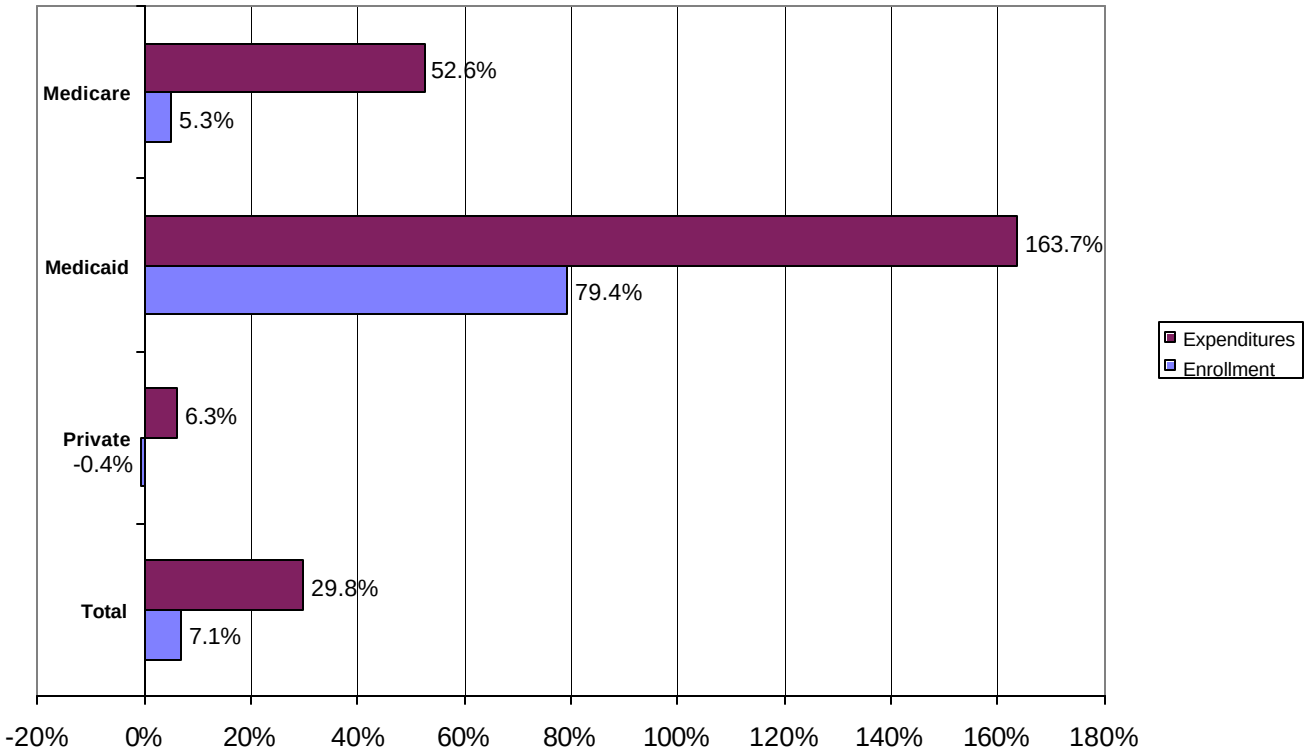
According to Table 3-5, private HMOs spend proportionately more than non-HMOs on physician services (38.7 percent and 30.1 percent, respectively) and a smaller share on prescription drugs (8.8 percent and 14.5 percent, respectively). Surprisingly, private HMOs appear to have spent a slightly larger share of expenditures than non-HMOs for inpatient care (23.0 percent and 21.1 percent, respectively), but this could reflect differences in the health status or the regional distribution of the two insured populations. Non-medical administrative expenditures represent 10.7 percent of total expenditures for private HMOs, but 16.3 percent of private non-HMO expenditures. Because HMOs reimburse some providers using capitation payments, claims processing costs—a significant component of administrative expenditures—are probably reduced.

Implementation of the HealthChoice Program resulted in most of the Maryland Medicaid population shifting into managed care organizations (MCOs) by the start of 1998. The Medicaid MCO enrollment increased to more than 51 percent of the total Medicaid population in 1998 and more than three-quarters of the

Medicaid population in categories that are eligible for HealthChoice.[14] This group excludes elderly residents who also qualify for Medicare (dually eligibles), as well as participants in the Maryland Pharmacy Assistance, Family Planning, and Maryland Kids Count programs. Maryland's shift from a primary care case management (PCCM) program to mandatory MCO enrollment mirrors the experience of many other states. Nationally, less than one-third of all Medicaid managed care enrollees were still in PCCM programs in 1996, for example.[15]

Figure 3-4 compares growth in expenditures and enrollments by type of delivery system for different types of payers. The figure shows that changes in HMO expenditures consistently outpace changes in enrollment across market segments.

Figure 3-4: Percent Change in Enrollment and Expenditures for HMOs: 1997-1998



NOTE: See footnote 14 regarding the Medicaid percentages reported in this figure.

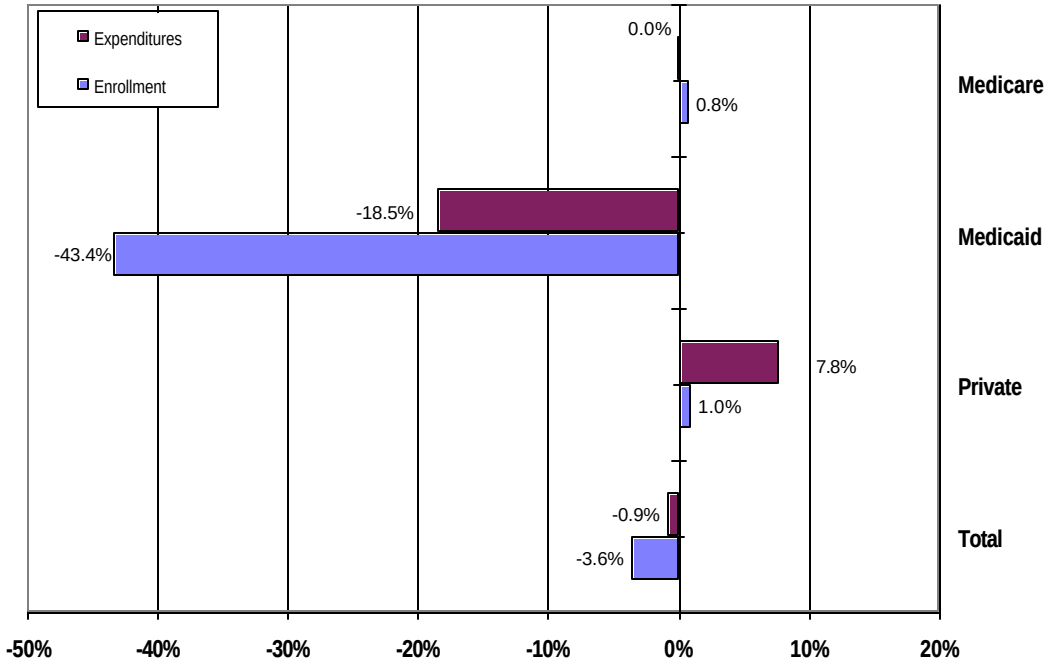
As shown in Figure 3-4, Medicare MCO expenditures increased by over 50 percent, while Medicare HMO enrollment increased by only 5.3 percent. Medicaid MCO expenditures almost tripled between 1997 and 1998, while MCO enrollment increased by 79.4 percent. In the private sector, the increase in HMO expenditures was much less (6.3 percent) than in the public sector. However, this increase occurred despite a small decline in enrollment (-0.4 percent). It is important to note that private HMO expenditures continue to represent the prevalence of managed care activity within the state.

The relationship between changes in non-HMO enrollment and expenditures is less consistent, as shown in Figure 3-5. Enrollment in traditional Medicare coverage increased 0.8 percent from 1997 to 1998, while expenditures were unchanged. In contrast, the number of Medicaid recipients outside of managed care arrangements declined 43.4 percent and their expenditures fell 18.5 percent. Private indemnity enrollment

[14] Numbers differ from those reported in Chapter 2 due to an altered methodology.
[15] Holahan J, Zuckerman S, Evans A, and Rangarajan S. Medicaid managed care in thirteen states, *Health Affairs*, 17 (3), pp. 43-63.

increased 1.0 percent, while expenditures went up 7.8 percent. In general, one would expect expenditure changes to outpace enrollment because the population that remains in indemnity-type arrangements tends to be more expensive to serve than the population that moves to HMOs. For example, the nursing home population and those who are dually eligible for Medicare and Medicaid are not currently eligible to enroll in Medicaid MCOs. The fact that Medicare did not conform to this pattern in 1998 could reflect real changes in the Medicare Program, perhaps due to the Balanced Budget Act of 1997, or it could be a statistical aberration associated with the use of new data sources to analyze Medicare expenditures in 1998.

Figure 3-5: Percent Change In Enrollment And Expenditures For Non-HMOs: 1997-1998



OUT-OF-POCKET EXPENDITURES

Out-of-pocket expenditures represent funds spent by residents for co-payments, co-insurance and deductibles, and for services that are not covered by a health plan. These types of expenditures occur for one of two reasons. On the one hand, they encourage enrollees not to use health care services in a wasteful or inappropriate manner. On the other hand, out-of-pocket expenditures occur because of gaps in insurance coverage. For this reason, it is helpful to understand how much Maryland residents pay out of their own pockets for health care, and more importantly, how those dollars are divided between cost-sharing for covered services and direct payments for uncovered forms of health care. Expenditures for uninsured services account for 66 percent of out-of-pocket spending in Maryland; cost-sharing for insured services accounts for the remaining 34 percent.

While out-of-pocket expenditures account for 17.0 percent of the overall health care dollars in Maryland and represent almost $3 billion (Table 3-10), they also account for over one-third, 36.2 percent, of all nursing home expenditures, 28.6 percent of all prescription drug expenditures, and 48.3 percent of services provided by health professionals other than physicians. These relatively high out-of-pocket expenditure rates represent the areas where health plans offer the least coverage to their enrollees. In contrast, out-of-pocket payments for hospital inpatient care are very low, representing only 2.5 percent of total inpatient expenditures and 3.4 percent of total out-of-pocket expenditures.

TABLE 3-10: PATTERNS OF OUT-OF-POCKET SPENDING, 1998 ($000s)

	Out-of-Pocket (OOP) Expenditures	Percent of Total OOP Expenditures	OOP as a Percent of Total Service Category Expenditures
Total Health Expenditures	$2,897,879	100%	17.0%
Hospital Services			
Inpatient	$99,524	3.4%	2.5%
Outpatient	$123,924	4.3%	8.9%
Physician Services	$628,774	21.7%	17.1%
Other Professional Services	$913,062	31.5%	48.3%
Prescription Drugs	$430,720	14.9%	28.6%
Nursing Home Care	$457,575	15.8%	36.2%
Home Health Care	$125,786	4.3%	20.7%
Other Services	$118,516	4.1%	50.6%

Out-of-pocket expenditures for physician (21.7 percent) and other professional services (31.5 percent) together account for more than half of all out-of-pocket spending. The next largest categories are nursing home care (15.8 percent), for which there is little private insurance coverage, and prescription drugs (14.9 percent), which are not covered by Medicare. Hospital services are fairly comprehensively covered by insurance programs, both public and private, and have relatively small out-of-pocket expenditures.

Out-of-pocket expenditures in Maryland grew 3.3 percent between 1997 and 1998 (Table 3-11). Total national out-of-pocket expenditures increased 3.5 percent this year. **Increases in out-of-pocket spending in Maryland were almost identical to the national increase. The increase in out-of-pocket expenditures was driven by an increase of 5.2 percent in expenditures on prescription drugs and an increase of 5.8 percent in other professional services, while other categories of services showed smaller increases, or even declines, in their out-of-pocket expenditures.** In Maryland, cost-sharing for insured services grew by 5.6 percent, accounting for most of the growth in out-of-pocket spending; expenditures for uninsured services increased by just 2.2 percent.

TABLE 3-11: CHANGES IN MARYLAND OUT-OF-POCKET SPENDING, 1997-1998 ($000s)

	Total Out-of-Pocket		Percent Change in Out-of-Pocket Spending	Percent Change in Total Spending
	1998	1997		
Total Health Expenditures	$2,897,879	$2,804,283	3.3%	5.3%
Hospital Services				
Inpatient	$99,524	$96,713	2.9%	-0.7%
Outpatient	$123,924	$124,295	-0.3%	0.2%
Physician Services	$628,774	$606,393	3.7%	0.2%
Other Professional Services	$913,062	$863,227	5.8%	2.7%
Prescription Drugs	$430,720	$409,625	5.1%	9.4%
Nursing Home Care	$457,575	$458,123	-0.1%	-6.6%
Home Health Care	$125,786	$125,009	0.6%	-6.4%
Other Services	$118,516	$120,898	-2.0%	-2.8%

Out-of-pocket per capita expenditures for the privately insured grew 6.2 percent in 1998 (Table 3-8). By way of comparison, total national out-of-pocket expenditures increased 5.8 percent from 1996 to 1997[16] and are projected to rise at an annual rate of 5.7 percent from 1997 to 1999,[17] closely matching the increase observed in Maryland.

[16] Health Care Financing Administration. National Health Expenditure Tables. Table 3. National Health Expenditures by Source of Funds and Type of Expenditure: Selected Calendar Years 1992-1997. http://www.hcfa.gov./stats/nhe-oact/tables/t11.htm (November 13, 1999).

[17] Health Care Financing Administration. National Health Care Expenditures Projections. http://www.hcfa.gov/stats/NHE-Proj (November 13, 1999).

It is useful to compare the increase in out-of-pocket expenditures with the overall change in expenditures. For example, out-of-pocket expenditures for hospital inpatient services increased 2.9 percent, while the overall hospital inpatient expenditures dropped by 0.7 percent. The increase in out-of-pocket expenditures for prescription drugs, while relatively large at 5.2 percent, was smaller than the overall increase in prescription drug expenditures of 9.4 percent (Table 3-11).

Large out-of-pocket costs can be indicative of financial barriers to adequate health care, especially among vulnerable populations. Medicare co-payments and deductibles, while only 0.5 percent of total health expenditures according to Appendix Table 1D, can be substantial for individual beneficiaries.[18] Out-of-pocket expenditures for Medicare co-insurance and deductibles declined in Maryland from 1997 to 1998. This decline is probably the result of two factors: (1) the large increase in Medicare HMO enrollment (see Chapter 2), where beneficiaries have lower co-payments for services compared with indemnity coverage, and (2) changes associated with the Balanced Budget Act of 1997, which reduced beneficiary co-payments for certain covered services.

SUMMARY

Overall growth in health care expenditures in Maryland during 1998 was 5.3 percent. This increase is somewhat higher than the slow rate of growth experienced since 1993. This increase is consistent with the projections for change in national health care spending during the same period. In Maryland, HMOs have a larger market share than in the rest of the nation, and the enrollment in Medicare and Medicaid HMOs is growing rapidly. About one-tenth of the state's 1998 expenditure increase was due to changes in Maryland's overall population, which grew about 0.8 percent. The majority of the remainder is attributable to inflation and aging of the population. Maryland's total health care spending in 1998 was $17.0 billion, an average of $3,064 per resident.[19]

Maryland's 1998 rate of growth for government payers was 4.4 percent, 0.9 percentage points less than the overall rate. Government spending on health care totaled $7.3 billion, or 42.7 percent of the total expenditures. Most of the government spending (88.6 percent) was funded by Medicare and Medicaid, which together accounted for 37.9 percent of total health care spending in the state.

Spending growth in the private sector, including private health insurance and out-of-pocket spending by consumers, was 6.0 percent overall. Out-of-pocket spending, which includes direct payments by consumers for deductibles, co-insurance, and uninsured products and services, evidenced a slightly lower rate of growth, 3.3 percent. With this increase, the out-of-pocket share of total spending was 17.0 percent in 1998. In 1998, private insurance spending grew by 7.2 percent, making private insurance's share of total health care spending 40.2 percent.

The HMO system in Maryland continued to expand, due entirely to changes in the government sector. Medicare HMO enrollment grew by 5.3 percent, while MCO enrollment under Medicaid grew by 56.5 percent. Private-sector HMO enrollment dropped by 0.4 percent. Over 40 percent of the total population is enrolled in HMOs. Although this would be expected to reduce overall spending by Medicaid, as discussed in Chapter 2, the anticipated savings were more than offset by increased prices for hospital services and prescription drugs, demand for new technologies (including new drugs), high capitation rates in the HealthChoice Program during 1998, and payments in 1998 for all mental health services that occurred in the last six months of 1997.

[18] Medicare Payment Advisory Commission. "Report to the Congress: Selected Medicare Issues," June 1999.
[19] This statewide per capita figure includes administration and the net cost of insurance.